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CHAPTER I
GENERAL CORRECT CODING POLICIES
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter I
General Correct Coding Policies

A. Introduction

The Physicians' Current Procedural Terminology (CPT) developed by the American Medical Association and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The codes in the *CPT Manual* are copyrighted by the AMA, and updated annually by the CPT Editorial Panel based on input from the AMA Advisory Committee which serves as a channel for requests from various providers and specialty societies. The purpose of both coding systems and annual updates is to communicate specific services rendered by physicians and other providers, usually for the purpose of claim submission to third party (insurance) carriers. A multitude of codes is necessary because of the wide spectrum of services provided by various medical care providers. Because many medical services can be rendered by different methods and combinations of various procedures, multiple codes describing similar services are frequently necessary to accurately reflect what service a physician performs. While often only one procedure is performed at a patient encounter, multiple procedures are performed at the same session at other times. In the latter case, the pre-procedure and post-procedure work does not have to be repeated and, therefore, a comprehensive code, describing the multiple services commonly performed together, can be defined.

Third party payers have adopted the CPT coding system for use by providers to communicate payable services. It therefore becomes more important to identify the various potential combinations of services to accurately adjudicate claims.

There are two sets of Correct Coding Initiative tables, column 1/column 2 correct coding (formerly known as comprehensive/component) edits and mutually exclusive edits. All edits consist of code pairs that are arranged in column 1 and column 2 of the tables. All edits are included in the first table except those meeting the criteria for mutually exclusive code edits (Chapter I, Section Q). Edits based on the criteria for “Gender-Specific Procedures” (formerly “Designation of Sex”) (Chapter I, Section R) are also included in the mutually exclusive code edit tables. The column 2 code in both tables is not payable with the column 1 code unless the edit permits use of a modifier associated with CCI (Chapter I, Section H). The

correct coding edit table contains many edits where the column 2 code is a component of the column 1 comprehensive code. However, this table also contains many edits where there is no comprehensive/component relationship, but the column 1 code and column 2 code should not be reported together for other reasons. The following policies encompass general issues/coding principles that are to be applied in all subsequent chapters. Specific examples are stated to clarify the policy but do not represent the only code or service that is included in the policy.

B. Coding Based on Standard of Medical/Surgical Practice

In order for this system to be effective, it is essential that the coding description accurately describe what actually transpired at the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event common to all procedures of a similar nature as part of the narrative description for a code. Many of these common activities reflect simply normal principles of medical/surgical care. These "generic" activities are assumed to be included as acceptable medical/surgical practice and, while they could be performed separately, they should not be considered as such when a code descriptor is defined. Accordingly, all services integral to accomplishing a procedure will be considered included in that procedure.

Many of these generic activities are common to virtually all procedures. On other occasions, some are integral to only a certain group of procedures but are still essential to accomplish these particular procedures. Accordingly, it would be inappropriate to separately code these services based on standard medical and surgical principles.

Some examples of generic services integral to standard of medical/surgical services would include:

- Cleansing, shaving and prepping of skin
- Draping of patient; positioning of patient
- Insertion of intravenous access for medication
- Sedative administration by the physician performing the procedure (see Chapter II, Anesthesia section, for the separate policy)
- Local, topical or regional anesthetic administered by physician performing procedure
- Surgical approach, including identification of anatomical landmarks, incision, evaluation of the surgical field, simple debridement of traumatized tissue, lysis of simple

adhesions, isolation of neurovascular, muscular (including stimulation for identification), bony or other structures limiting access to surgical field
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, dressings, pumps into same site
- Surgical closure
- Application, management, and removal of postoperative dressings including analgesic devices (peri-incisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided
- Surgical supplies, unless excepted by existing CMS policy

In the case of individual services, there are numerous specific services that may typically be involved in order to accomplish a column 1 procedure. Generally, performance of these services represents the standard of practice for a more comprehensive procedure and the services are therefore to be included in that service.

Because many of these services are unique to individual CPT coding sections, the rationale for correct coding will be described in that particular section. The principle of the policy to include these services into the column 1 procedure remains the same as the principle applied to the generic service list noted above. Specifically, these principles include:

1. The service represents the standard of care in accomplishing the overall procedure.

2. The service is necessary to successfully accomplish the column 1 procedure; failure to perform the service may compromise the success of the procedure.

3. The service does not represent a separately identifiable procedure unrelated to the column 1 procedure planned.

Specific examples consist of:

<u>Medical:</u>

1. Procurement of a rhythm strip in conjunction with an electrocardiogram. The rhythm strip would not be separately

reported if it was procured by the same physician performing the interpretation, since it is an integral component of the interpretation.

2. Procurement of upper extremity (brachial) Doppler study in addition to lower extremity Doppler study in order to obtain an "ankle-brachial index" (ABI). The upper extremity Doppler would not be separately reported.

3. Procurement of an electrocardiogram as part of a cardiac stress test. The electrocardiogram would not be separately reported if procured as a routine serial EKG typically performed before, during, and after a cardiac stress test.

Surgical:

1. Removal of a cerumen impaction prior to myringotomy. The cerumen impaction is precluding access to the tympanic membrane and its removal is necessary for the successful completion of the myringotomy.

2. Performance of a bronchoscopy prior to a thoracic surgery (e.g. thoracotomy and lobectomy). Assuming that a diagnostic bronchoscopy has already been performed for diagnosis and biopsy and the surgeon is simply evaluating for anatomic assessment for sleeve or more complex resection, the bronchoscopy would not be separately reported. Essentially, this "scout" endoscopy represents a part of the assessment of the surgical field to establish anatomical landmarks, extent of disease, etc. If an endoscopic procedure is done as part of an open procedure, it is not separately reported. However, if an endoscopy is performed for purposes of an initial diagnosis on the same day as the open procedure, the endoscopy is separately reported. In the case where the procedure is performed for diagnostic purposes immediately prior to a more definitive procedure, the -58 modifier may be utilized to indicate that these procedures are staged or planned services. Additionally, if endoscopic procedures are performed on distinct, separate areas at the same session, these procedures would be reported separately. For example, a thoracoscopy and mediastinoscopy, being separate endoscopic procedures, would be separately reported. On the other hand, a cursory evaluation of the upper airway as part of bronchoscopic procedure would not be separately reported as a laryngoscopy, sinus endoscopy, etc.

3. Lysis of adhesions and exploratory laparotomy reported with colon resection or other abdominal surgery. These

procedures represent gaining access to the organ system of interest and are not separately reported.

C. Medical/Surgical Package

As a result of the variety of surgical, diagnostic and therapeutic non-surgical procedures commonly performed in medical practice, the extent of the *CPT Manual* has grown. The need for precise definitions for the various combinations of services is further warranted because of the dependence of providers on CPT coding for reporting to third party payers. When a Resource-Based Relative Value System (RBRVS) is used in conjunction with CPT coding, the necessity for accurate coding is amplified. In general, most services have pre-procedure and post-procedure work associated with them; when performed at a single patient encounter, the pre-procedure and post-procedure work does not change proportionately when multiple services are performed. Additionally, the nature of the pre-procedure and post-procedure work is reasonably consistent across the spectrum of procedures.

In keeping with the policy that the work typically associated with a standard surgical or medical service is included in the *CPT Manual* code description of the service, some general guidelines can be developed. With few exceptions these guidelines transcend a majority of CPT descriptions, irrespective of whether the service is limited or comprehensive.

1. A majority of invasive procedures require the availability of vascular and/or airway access; accordingly, the work associated with obtaining this access is included in the pre-procedure services and returning a patient to the appropriate post-procedure state is included in the procedural services. Intravenous access, airway access (e.g. HCPCS/CPT codes 36000, 36400, 36410) are frequently necessary; therefore, CPT codes describing these services are not separately reported when performed in conjunction with a column 1 procedure. Airway access is associated with general anesthesia, and no CPT code is available for elective intubation. The CPT code 31500 is not to be reported for elective intubation in anticipation of performing a procedure as this represents a code for providing the service of emergency intubation.

Furthermore, CPT codes describing services to gain visualization of the airway (nasal endoscopy, laryngoscopy, bronchoscopy) were created for the purpose of coding a diagnostic or therapeutic service and are not to be reported as a part of intubation services.

When vascular access is obtained, the access generally requires maintenance of an infusion or use of an anticoagulant (heparin lock injection) (e.g. CPT codes 90780 - 90784). These services are necessary for the maintenance of the access and are not to be separately reported. Additionally, use of an anticoagulant for access maintenance cannot be separately reported (e.g. CPT code 37201).

In some situations, more invasive access services (central venous access, pulmonary artery access) are performed with a specific type of procedure. Because this is not typically the case, the codes referable to these services may be separately reported.

Placement of central access devices (central lines, pulmonary artery catheters, etc.) involve passage of catheters through central vessels and, in the case of PA catheters, through the right ventricle; additionally, these services often require the use of fluoroscopic support. Separate reporting of CPT codes for right heart catheterization, first order venous catheter placement or other services which represent a separate procedure, is not appropriate when the CPT code that describes the access service is reported. General fluoroscopic services necessary to accomplish routine central vascular access or endoscopy cannot be separately reported unless a specific CPT code has been defined for this service.

2. When anesthesia is provided by the physician performing the primary service, the anesthesia services are included in the primary procedure (CMS Anesthesia Rules). If it is medically necessary for a separate provider (anesthesiologist/ anesthetist) to provide the anesthesia services (e.g. monitored anesthesia care), a separate service may be reported.

3. Most procedures require cardiopulmonary monitoring, either by the physician performing the procedure or an anesthesiologist/certified registered nurse anesthetist. Because these services are integral and routine, they are not to be separately reported. This may include cardiac monitoring, intermittent EKG procurement, oximetry or ventilation management (e.g. CPT codes 93000, 93005, 93040, 93041, 94656, 94760, 94761, 94770). These services, when integral to the monitoring service, are not to be separately reported.

4. When, in the course of a procedure, a non-diagnostic biopsy is obtained and subsequently excision, removal, destruction or other elimination of the biopsied lesion is

accomplished, a separate service cannot be reported for the biopsy procurement as this represents part of the removal. When a single lesion is biopsied multiple times, only one biopsy removal service should be reported. When multiple distinct lesions are non-endoscopically biopsied, a biopsy removal service may be reported for each lesion separately with a modifier, indicating a different service was performed or a different site was biopsied (see Section H of Chapter I for definition of the -59 modifier). The medical record (e.g. operative report) should indicate the distinct nature of this service. However, for endoscopic biopsies of lesions, multiple biopsies of multiple lesions are reported with one unit of service regardless of how many biopsies are taken. If separate biopsy removal services are performed on separate lesions, and it is felt to be medically necessary to submit pathologic specimens separately, the medical record should identify the precise location of each biopsy site. If the decision to perform a more comprehensive procedure is based on the biopsy result, the biopsy is diagnostic, and the biopsy service may be separately reported.

5. In the performance of a surgical procedure, it is routine to explore the surgical field to determine the anatomic nature of the field and evaluate for anomalies. Accordingly, codes describing exploratory procedures (e.g. CPT code 49000) cannot be separately reported. If a finding requires extension of the surgical field and it is followed by another procedure unrelated to the primary procedure, this service may be separately reported using the appropriate CPT code and modifiers.

6. When a definitive surgical procedure requires access through abnormal tissue (e.g. diseased skin, abscess, hematoma, seroma, etc.), separate services for this access (e.g. debridement, incision and drainage) are not reported. For example, if a patient presents with a pilonidal cyst and it is determined that it is medically necessary to excise this cyst, it would be appropriate to submit a bill for CPT code 11770 (excision of pilonidal cyst); it would not, however, be appropriate to also report CPT code 10080 (incision and drainage of pilonidal cyst), as it was necessary to perform the latter to accomplish the primary procedure.

7. When an excision and removal is performed ("-ectomy" code), the approach generally involves incision and opening of the organ ("-otomy" code). The incision and opening of the organ or lesion cannot be separately reported when the primary service is the removal of the organ or lesion.

8. There are frequently multiple approaches to various procedures, and are often clusters of CPT codes describing the various approaches (e.g. vaginal hysterectomy as opposed to abdominal hysterectomy). These approaches are generally mutually exclusive of one another and, therefore, not to be reported together for a given encounter. Only the definitive, or most comprehensive, service performed can be reported. Endoscopic procedures are often performed as a prelude to, or as a part of, open surgical procedures. When an endoscopy represents a distinct diagnostic service prior to an open surgical service and the decision to perform surgery is made on the basis of the endoscopy, a separate service for the endoscopy may be reported. The -58 modifier may be used to indicate that the diagnostic endoscopy and the open surgical service are staged or planned procedures.

9. When an endoscopic service is performed to establish the location of a lesion, confirm the presence of a lesion, establish anatomic landmarks, or define the extent of a lesion, the endoscopic service is not separately reported as it is a medically necessary part of the overall surgical service. Additionally, when an endoscopic service is attempted and fails and another surgical service is necessary, only the successful service is reported. For example, if a laparoscopic cholecystectomy is attempted and fails and an open cholecystectomy is performed, only the open cholecystectomy can be reported; if appropriate, a -22 modifier may be added to indicate unusual procedural services.

10. A number of CPT codes describe services necessary to address the treatment of complications of the primary procedure (e.g. bleeding or hemorrhage). When the services described by CPT codes as complications of a primary procedure require a return to the operating room, they may be reported separately; generally, due to global surgery policy, they should be reported with the -78 modifier indicating that the service necessary to treat the complication required a return to the operating room during the postoperative period. When a complication described by codes defining complications arises during an operative session, however, a separate service for treating the complication is not to be reported. An operative session ends upon release from the operating or procedure suite (as defined in MCM §4821).

D. Evaluation and Management Services

All CPT and HCPCS Level II codes have a global surgery indicator. The separate payment for Evaluation and Management (E & M) services provided on the same day of service as procedures with a global surgery indicator of "000," "010," or "090" are covered by global surgery rules.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E & M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E & M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E & M service on the same day of service which may be reported by appending the modifier –25 to the E & M code. This E & M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending the modifier –25 to a significant, separately identifiable E & M service when performed on the same date of service as an "XXX" procedure is correct coding.

E. Standard Preparation/Monitoring Services

Anesthesia services require certain other services to prepare a patient prior to the administration of anesthesia and to monitor a patient during the course of anesthesia. The advances in technology allow for intraoperative monitoring of a variety of physiological parameters. Additionally, when monitored anesthesia care is provided, the attention devoted to patient monitoring is of a similar level of intensity so that general anesthesia may be established if need be. The specific services necessary to prepare and monitor a patient vary among procedures,

based on the extent of the surgical procedure, the type of anesthesia (general, MAC, regional, local, etc.), and the surgical risk. Although a determination as to medical necessity and appropriateness must be made by the physician performing the anesthesia, when these services are performed, they are included in the anesthesia service. Because it is recognized that many of these services may occur on the same date of surgery but are not performed in the course of and as part of the anesthesia provision for the day, in some cases these codes will be separately paid by appending the -59 modifier, indicating that the service rendered was independent of the anesthesia service.

F. Anesthesia Service Included in the Surgical Procedure

Under the CMS Anesthesia Rules, Medicare does not allow separate payment for the anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical service. For example, separate payment is not allowed for the surgeon's performance of local, regional, or other anesthesia including nerve blocks if the surgeon also performs the surgical procedure.

CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia should not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician. Examples of improperly reported services that are bundled into the anesthesia service when anesthesia is provided by the physician performing the medical or surgical service include introduction of needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or intravenous infusion (CPT code 97080). However, if these services are not related to the delivery of an anesthetic agent, they may be reported separately.

G. Coding Services Supplemental to a Principal Procedure (Add-on Codes)

The CPT coding system identifies certain codes which are to be submitted in addition to other codes. Generally, these are identified with the statement "list separately in addition to code for primary procedure" in parentheses and other times the supplemental code is to be used only with certain primary codes which are parenthetically identified. The basis for these CPT codes is to enable providers to separately identify a service

that is performed in certain situations as an additional service or a commonly performed supplemental service complementary to the primary procedure. Incidental services that are necessary to accomplish the primary procedure (e.g. lysis of adhesions in the course of an open cholecystectomy) are not separately reported. Certain complications with an inherent potential to occur in an invasive procedure are, likewise, not separately reported unless resulting in the necessity for a significant separate procedure to be performed. For example, control of bleeding during a procedure is considered part of the procedure and is not separately reported.

Supplemental codes frequently specify codes or ranges of codes with which they are to be used. It would be inappropriate to use these with codes other than those specified. On occasion, a procedure described by a CPT code is modified or enhanced, either due to the unique nature of the clinical situation or due to advances in technology since the code was first published. When CPT codes are not labeled as supplemental codes in the manner described above, they are not to be reported unless the actual procedure is, in fact, performed. Using non-supplemental codes that approximate part of a more comprehensive procedure but do not describe a separately identifiable service is not appropriate.

Example: If, in the course of interpreting an echocardiogram, an ejection fraction is estimated, it would be inappropriate to code a cardiac blood pool imaging with ejection fraction determination (CPT code 78472) in addition to an echocardiography code (CPT code 93307.) Although the cardiac blood pool imaging does determine an ejection fraction, it does so by nuclear gaiting techniques which are not used in an echocardiogram.

In other cases codes are interpreted as being supplemental to a primary code without an explicit statement in the *CPT Manual* that the code is supplemental. Unless the code is explicitly identified in such a fashion, it would be improper as a coding convention to submit a primary procedure code as a supplemental code.

H. Modifiers

In order to expand the information provided by CPT codes, a number of modifiers have been created by the AMA, and the CMS. These modifiers, in the form of two characters, either numbers, letters, or a combination of each, are intended to transfer specific information regarding a certain procedure or service.

Modifiers are attached to the end of a HCPCS/CPT code and give the physician a mechanism to indicate that a service or procedure has been modified by some circumstance but is still described by the code definition.

Like CPT codes, the use of modifiers (either AMA or CMS-defined modifiers) requires explicit understanding of the purpose of each modifier. It is also important to identify when the purpose of a modifier has been expanded or restricted by a third party payer. It is essential to understand the specific meaning of the modifier by the payer to which a claim is being submitted before using it.

There are modifiers created by either the AMA or the CMS which have been designated specifically for use with the correct coding and mutually exclusive code pairs. These modifiers are -E1 through -E4, -FA, -F1 through -F9, -LC, -LD, -LT, -RC, -RT, -TA, -T1 through -T9, -25, -58, -59, -78, -79, and -91. When one of these modifiers is used, it identifies the circumstances for which both services rendered to the same beneficiary, on the same date of service, by the same provider should be allowed separately because one service was performed at a different site, in a different session, or as a distinct service. The -59 modifier will be explained in greater detail in this section. In addition, pertinent information about three other modifiers, the –22, the –25, and the -58 is provided.

1. **-22 Modifier:** The -22 modifier is identified in the *CPT Manual* as "unusual procedural services." By definition, this modifier would be used in <u>unusual</u> circumstances; routine use of the modifier is inappropriate as this practice would suggest cases routinely have unusual circumstances. When an unusual or extensive service is provided, it is more appropriate to utilize the -22 modifier than to report a separate code that does not accurately describe the service provided.

2. **-25 Modifier**: The –25 modifier is identified in the *CPT Manual* as a "significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service". This modifier may be appended to an evaluation and management (E & M) code reported with another procedure on the same day of service. CCI includes edits bundling E & M codes into various procedures not covered by global surgery rules. If in addition to the procedure the physician performs a significant and separately identifiable E & M service beyond the usual pre-procedure, intra-procedure, and post-procedure physician work, the E & M may be reported with

the –25 modifier appended. The E & M and procedure(s) may be related to the same or different diagnoses.

3. **-58 Modifier:** The -58 modifier is described as a "staged or related procedure or service by the same physician during the postoperative period." It indicates that a procedure was followed by another procedure or service during the postoperative period. This may be because it was planned prospectively, because it was more extensive than the original procedure or because it represents therapy after a diagnostic procedural service. When an endoscopic procedure is performed for diagnostic purposes at the time of a more comprehensive therapeutic procedure, and the endoscopic procedure does not represent a "scout" endoscopy, the -58 modifier may be appropriately used to signify that the endoscopic procedure and the more comprehensive therapeutic procedure are staged or planned procedures. From the National Correct Coding Initiative perspective, this action would result in the allowance and reporting of both services as separate and distinct.

4. **-59 Modifier:** The -59 modifier has been established for use when several procedures are performed on different anatomical sites, or at different sessions (on the same day). The specific language according to the *CPT Manual* is:

-59 Modifier: "Distinct procedural service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier -59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician."

When certain services are reported together on a patient by the same physician on the same date of service, there may be a perception of "unbundling," when, in fact, the services were performed under circumstances which did not involve this practice at all. Because carriers cannot identify this based simply on CPT coding on either electronic or paper claims, the -59 modifier was established to permit services of such a nature to bypass correct coding edits if the modifier is present. The -59 modifier indicates that the procedure represents a distinct service from others reported on the same date of service. This may represent

a different session, different surgery, different site, different lesion, different injury or area of injury (in extensive injuries). Frequently, another, already established, modifier has been defined that describes this situation more specifically. In the event that a more descriptive modifier is available, it should be used in preference to the -59 modifier.

Example: If a patient requires placement of a flow directed pulmonary artery catheter for hemodynamic monitoring via the subclavian vein, it would be appropriate to submit the CPT code 93503 (Insertion and placement of flow directed catheter, e.g. Swan-Ganz for monitoring purposes) for the service. If, later in the day, the catheter must be removed and a central venous catheter is inserted through the femoral vein, the appropriate code for this service would be CPT code 36010 (Introduction of catheter, superior or inferior vena cava). Because the pulmonary artery (PA) catheter requires passage through the vena cava, it may appear that the service for the PA catheter was being "unbundled" if both services were reported on the same day. Accordingly, the central venous catheter code should be reported with the -59 modifier (CPT code 36010 –59) indicating that this catheter was placed in a different site as a different service on the same day.

Other examples of the appropriate use of the -59 modifier are contained in the individual chapter policies.

The –59 modifier is often misused. The two codes in a code pair edit often by definition represent different procedures. The provider cannot use the –59 modifier for such an edit based on the two codes being different procedures. However, if the two procedures are performed at separate sites or at separate patient encounters on the same date of service, the –59 modifier may be appended. Additionally, the –59 modifier cannot be used with E & M services (CPT codes 99201-99499) or radiation treatment management (CPT code 77427).

Example: The column 1/column 2 code edit with column 1 code 38221 (bone marrow biopsy) and column 2 code 38220(bone marrow, aspiration only) are two distinct procedures when performed at separate anatomic sites or separate patient encounters. In these circumstances, it would be acceptable to use the –59 modifier. However, if both 38221 and 38220 are performed through the same skin incision at the same patient encounter which is the usual practice, the –59 modifier should NOT be used. Although 38221 and 38220 are different procedures, they are bundled when

performed through the same skin incision at a single patient encounter.

I. HCPCS/CPT Procedure Code Definition

The format of the *CPT Manual* includes descriptions of procedures which are, in order to conserve space, not listed in their entirety for all procedures. The partial description is indented under the main entry, and constitutes what is always followed by a semicolon in the main entry. The main entry then encompasses the portion of the description preceding the semicolon. The main entry applies to and is a part of all indented entries which follow with their codes. An example is:

70120	Radiologic examination, mastoids; less than three views per side
70130	complete, minimum of three views per side

The common portion of the description is "radiologic examination, mastoids" and this description is considered a part of both codes. The distinguishing part of each of these codes is that which follows the semicolon.

In some procedure descriptions, the code definition specifies other procedures that are included in this comprehensive code. CPT procedure code 58291 is an example. Since the code description for CPT code 58291 states that the code includes removal of tube(s)and/or ovary(s), it follows that salpingo-oophorectomy (CPT code 58720) cannot be reported with CPT code 58291.

In addition, a code description may define a correct coding relationship where one code is a part of another based on the language used in the descriptor. Some examples of this type of correct coding by code definition are:

1. "Partial" and "complete" CPT codes are reported. The partial procedure is included in the complete procedure.

2. "Partial" and "total" CPT codes are reported. The partial procedure is included in the total procedure.

3. "Unilateral" and "bilateral" CPT codes are reported. The unilateral procedure is included in the bilateral procedure.

4. "Single" and "multiple" CPT codes are reported. The single procedure is included in the multiple procedure.

5. “With” and “without” CPT codes are reported. The “without” procedure is included in the “with” procedure.

J. HCPCS/CPT Coding Manual Instruction/Guideline

Each of the six major sections of the *CPT Manual* and several of the major subsections include guidelines that are unique to that section. These directions are not all inclusive or limited to definitions of terms, modifiers, unlisted procedures or services, special or written reports, details about reporting separate, multiple or starred procedures and qualifying circumstances. These instructions appear in various places and are found at the beginning of each major section, at the beginning of subsections, and before or after a series of codes or individual codes. They define items or provide explanations that are necessary to appropriately interpret and report the procedures or services and to define terms that apply to a particular section. Notations are made in parentheses when CPT codes are deleted or cross-referenced to another similar code so that the provider has better guidance in the appropriate assignment of a CPT code for the service. Providers should not report CPT codes that are contrary to CPT instructions.

K. Separate Procedure

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a "separate procedure." The inclusion of this statement indicates that the procedure, can be performed separately but should not be reported when a related service is performed. The "separate procedure" designation is used with codes in the surgery (CPT codes 10000-69999), radiology (CPT codes 70000-79999) and medicine (CPT codes 90000-99199) sections. When a related procedure is performed, a code with the designation of "separate procedure" is not to be reported with the primary procedure.

Example: If the code identified as a "separate procedure" is reported with a related procedure code, such as when a sesamoidectomy, thumb or finger (CPT code 26185) is reported with an excision or curettage of a bone cyst or benign tumor of the proximal, middle, or distal phalanx of the finger with autograft (CPT code 26215), then the sesamoidectomy (separate procedure) should not be reported. By definition the "separate procedure" is commonly performed as integral and part of a larger service and usually represents a procedure that the physician performs

through the same incision or orifice, at the same site, or using the same approach.

In the case where a "separate procedure" is performed on the same day but at a different session, or at an anatomically unrelated site, the "separate procedure" code may be reported in addition to a code for a procedure that would be related if performed at the same patient encounter or at an anatomically related site. Modifier –59 should be included indicating that this service was, in fact, a separate service.

In other sections of the *CPT Manual*, the word "separate" is used in a phrase identified as "separate or multiple procedures" with a different meaning.

L. Family of Codes

In a family of codes, there are two or more component codes that are not reported separately because they are included in a more comprehensive code as members of the code family. Comprehensive codes include certain services that are separately identifiable by other component codes. The component codes as members of the comprehensive code family represent parts of the procedure that should not be listed separately when the complete procedure is done. However, the component codes are considered individually if performed independently of the complete procedure and if not all the services listed in the comprehensive codes were rendered to make up the total service. If all multiple services described by a comprehensive code are performed, the comprehensive code should be reported. It is not appropriate to report the separate component codes individually nor is it appropriate to report the component code (s) with the comprehensive code.

M. More Extensive Procedure

When procedures are performed together that are basically the same, or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is included in the more extensive procedure. In the following situations, the procedure viewed as the most complex would be reported:

1. "Simple" and "complex" CPT codes reported; the simple procedure is included in the complex procedure on the same site.

2. "Limited" and "complete" CPT codes reported; the limited procedure is included in the complete procedure on the same site.

3. "Simple" and "complicated" CPT codes reported; the simple procedure is included in the complicated procedure on the same site.

4. "Superficial" and "deep" CPT codes reported; the superficial procedure is included in the deep procedure on the same site.

5. "Intermediate" and "comprehensive" CPT codes reported; the intermediate procedure is included in the comprehensive procedure on the same site.

6. "Incomplete" and "complete" CPT codes reported; the incomplete procedure is included in the complete procedure on the same site.

7. "External" and "internal" CPT codes reported; the external procedure is included in the internal procedure on the same site.

N. Sequential Procedure

An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service; these procedures are considered "sequential procedures". Only the CPT code for one of the services, generally the more invasive service, should be reported. An example of this situation is a failed laparoscopic cholecystectomy, followed by an open cholecystectomy at the same session. Only the code for the successful procedure, in this case the open cholecystectomy, should be reported.

O. Laboratory Panel

When all component tests of a specific organ or disease oriented laboratory panel (e.g. CPT codes 80074,80061) are reported separately, they should be reported in the comprehensive panel code that includes the multiple component tests. The individual tests that make up a panel are not to be separately reported.

Example: CPT code 80061(Lipid panel) includes the following tests:

CPT code 82465: Cholesterol, serum or whole blood, total

CPT code 83718:	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
CPT code 84478:	Triglycerides

When all 3 tests are performed, the panel test (CPT code 80061) should be reported in place of the individual tests.

P. Misuse of Column 2 Code with Column 1 Code

In general, CPT codes have been written as precisely as possible to not only describe a specific service or procedure but to also avoid describing similar services or procedures which are already defined by other CPT codes. When a CPT code is reported, the physician or non-physician provider must have performed all of the services noted in the descriptor unless the descriptor states otherwise. (Frequently, a CPT descriptor will identify certain services that may or may not be included, usually stating "with or without" a service.) A provider should not report a CPT code out of the context for which it was intended. Providers who are familiar with procedures or services described in areas or sections of CPT will understand the specific language of the descriptor as well as the intent for which the code was developed. On the other hand, a provider who, for example, is unfamiliar with an area of CPT may fail to understand the intent of certain codes. Either intentionally or unintentionally, a provider may report a service or procedure using a CPT code that may be construed to describe the service/procedure but, in no way, was intended to be used in this fashion.

CPT codes describing services or procedures that would not typically be performed with other services or procedures but may be construed to represent other services have been identified and paired with the column 1 CPT codes. Additionally, pairs of codes have been identified which would not be reported together because another code more accurately describes the services performed.

Example: CPT code 20550 ("Injection(s); tendon sheath, ligament") is intended to describe a therapeutic musculoskeletal injection. It would represent a misuse of the code to report this code with other procedures (e.g. 20520 for simple removal of foreign body in muscle or tendon sheath) when the only service provided was injection of local anesthesia in order to accomplish the latter procedure.

Q. Mutually Exclusive Procedure

There are numerous procedure codes that are not to be reported together because they are mutually exclusive of each other. Mutually exclusive codes are those codes that cannot reasonably be done in the same session. An example of a mutually exclusive situation is when the repair of the organ can be performed by two different methods. One repair method must be chosen to repair the organ and must be reported. A second example is the reporting of an "initial" service and a "subsequent" service. It is contradictory for a service to be classified as an initial and a subsequent service at the same time.

CPT codes that are mutually exclusive of one another based either on the CPT definition or the medical impossibility/improbability that the procedures could be performed at the same session can be identified as code pairs. These codes are not necessarily linked to one another with one code narrative describing a more comprehensive procedure compared to the component code, but can be identified as code pairs that should not be reported together.

In order to identify these code pairs, an independent table of mutually exclusive codes has been developed as part of the CCI. This table differs from the correct coding table of column 1 and column 2 codes. Although the codes are listed as column 1 and column 2 codes, the column 2 code is not a component or part of the column 1 code. Rather the two codes cannot be reported at the same time.

R. Gender-Specific Procedure (formerly Designation of Sex)

Many procedure codes have a gender-specific classification within their narrative. These codes are not reported with codes having the opposite gender designation because this would reflect a conflict in gender classification either by the definition of the code descriptions themselves (as they appear in the *CPT Manual*) or by the fact that the performance of these procedures on the same patient would be anatomically impossible.

The sections that this policy pertains to are the male and female genital procedures. Other codes indicate in their definition that a particular gender classification is required for the use of that particular code. An example of this situation would be CPT code 53210 for total urethrectomy including cystostomy in a female as opposed to CPT code 53215 for the male. Both of these procedures are not to be reported together. Some other examples of these code pairs are: 53210-53250, 52275-52270, and 57260-

53620. These specific edits have been included in the Mutually Exclusive Table because both procedures of a code pair edit cannot be performed on a patient. (See Section Q in this chapter for more explanation of mutually exclusive codes.)

S. Excluded Service

Because some procedures are identified as excluded from coverage under the Medicare program as "excluded services," there is no need to address the issue of correct coding with these codes. In the development of National Correct Coding Policy and Correct Coding Edits, these excluded services have been ignored.

T. Unlisted Service or Procedure

The codes listed after each section and/or subsection which end in -99 (or a single -9 in a few cases) are used to report a service that is not described in any code listed elsewhere in the *CPT Manual*. Because of advances in technology or physician expertise with new procedures, a code may not be assigned to a procedure when the procedure is first introduced as accepted treatment. The unlisted service or procedure codes are then necessary to code the service. Every effort should be made to find the appropriate code to describe the service and frequent use of these unlisted codes instead of the proper codes is not appropriate. Correct code assignment would occur after the documentation has been reviewed and bundling of code pairs would then take place based on the changed code or correctly submitted code. The unlisted service or procedure codes have not been included in the Correct Coding Policy or Edits because of the multiple procedures that can be assigned to these codes.

U. Modified, Deleted, and Added Code Pairs/Edits

Correct coding (column 1/column 2) and mutually exclusive code pairs/edits have been developed based on the coding conventions defined in the American Medical Association's *CPT Manual* instructions and CPT code descriptions, national and local Medicare policies and edits, the coding guidelines developed by national societies, the analysis of standard medical and surgical practice, and the review of provider billing patterns and current coding practice. Prior to initial implementation, the proposed code pairs/edits underwent scrutiny by Medicare Part B carriers and physicians including Carrier Medical Directors, representatives of the American Medical Association's CPT Advisory Committee, and other national medical societies. As a

part of the ongoing refinement of the National Correct Coding Initiative, a process has been established to address annual changes in CPT and HCPCS Level II codes and manual instructions such as additions, deletions, and modifications of existing codes and guidelines. Additionally, ongoing changes occur based on changes in technology, and standard medical practice, and from continuous input from the AMA, and various specialty societies. During the refinement process, correspondence is received from the AMA, national medical societies, CMS Central and Regional Offices, Contractor Medical Directors, Medicare Part B carriers, individual providers, physicians' consultants and other interested parties. The comments and recommendations are evaluated and considered for possible modification or deletion of existing code pairs/edits or additions of new code pairs/edits. Subsequently based on the contributions from these sources, CMS Central Office decides which code pairs/edits are modified, deleted, or added.